Addendum to DUA for MA DHCFP's "The Role of Pu Massachusetts Health Care Exp		ce in If this is an addendum to a previously				
approved DUA, insert the CMS assigned DUA nu						
may/will have access to CMS data that is being req						
to the terms of this Data Use Agreement:						
Michelle Anderson / Programm	00					
Name and Title of Individual (typed or printed)			•			
Task / Role of this individual in this project		Company / Oro	ganization			
trogrammer / Analyst		DHCFY-	ر ــــــــــــــــــــــــــــــــــــ			
Street Address 2 Boy/5100 Street						
City	State		ZIP Code .			
Boston	M	P	02116			
Office Telephone (Include Area Code) 6.7 9 8 8 3 2 8 3	•	E-Mail Address (If applicable) Michelle. Anderson o State MA. W				
Signature of Intlividual Middle ConCon		Date 6 - 8 - 2010				
Signature of CMS Representative		Date				
Signature of CMS Project Officer (If applicable)		Date				
Name and Title of Individual (typed or printed)						
Task / Role of this individual in this project		Company / Organization				
Street Address						
City	State		ZIP Code			
Office Telephone (Include Area Code)		E-Mail Address	S (If applicable)			
Signature of Individual		Date				
Signature of CMS Representative		Date				
Signature of CMS Project Officer (If applicable)		Date	· .			

Addendum to DUA for	MA DHCFP's "The Role Massachusetts Health Car	of Publically l re Expenditure	Financed Insura		addendum to a previously
approved DUA, insert the	ne CMS assigned DUA in CMS data that is being re	number he	re:		he following individual(s) ares attest to their agreement
Name and Title of Individ John Cai	ual (typed or printed)				
Task / Role of this individe Analyst	ual in this project		Company Division	Organization of Healthcare F	inance and Policy
Street Address 2 Boylston Street	· ·	1, 1, 1			
City Boston	n voisi	State	MA	ZIP Code	02116
Office Telephone (Include A (617) 988-3137	rea Code)		E-Mail Add john.cai(ress (If applicable) Østate.ma.us	
Signature of Individual	L-		Date 06/09/20	10	
Signature of CMS Repres	entative		Date		
Signature of CMS Project	Officer (If applicable)		Date		
			,		
Name and Title of Individ	ual (typed or printed)				
Task / Role of this individ	ual in this project		Company	/ Organization	
Street Address			<u>.</u>		
City		State		ZIP Code	
Office Telephone (Include A	rea Code)		E-Mail Add	lress (If applicable)	Anna de Maria de Anna de Angeleiro de Companio de Comp
Signature of Individual			Date		
Signature of CMS Repres	entative		Date		
Signature of CMS Project	Officer (If applicable)		Date		

Addendum to DUA for MADHCFP's "The Role of Massachusetts Health Care H		. 22	in If this is an addendum to a previously
approved DUA, insert the CMS assigned DUA nu	ımber he	re;	. The following individual(s)
may/will have access to CMS data that is being req			
to the terms of this Data Use Agreement:			
Name and Title of Individual (typed or printed) Chris Campeau		.,,,,,	
Task / Role of this individual in this project Software Engineer		Company / C MA DHCF	Organization P
Street Address 2 Boylston Street	,		
City Boston	State	MA	ZIP Code 02114
Office Telephone (Include Area Code) (617) 988-3154		E-Mail Addre	oss (If applicable)
Signature of Individual		Date 06/07/201	0
Signature of CMS Representative		Date	-
Signature of CMS Project Officer (If applicable)		Date	
•			
Name and Title of Individual (typed or printed)			·
Task / Role of this individual in this project		Company / 0	Organization
Street Address			
City	State		ZIP Code
Office Telephone (Include Area Code)	<u> </u>	E-Mail Addre	SS (If applicable)
Signature of Individual		Date	
Signature of CMS Representative		Date	
Signature of CMS Project Officer (If applicable)	~	Date	

Addendum to DUA for Massachusetts Health Care Expe approved DUA, insert the CMS assigned DUA numay/will have access to CMS data that is being require to the terms of this Data Use Agreement:	^{nditures} ." mber he	re:				
Name and Title of Individual (typed or printed) Michael Cheung, Health Policy Analyst						
Task / Role of this individual in this project Programmer, Analyst	Company /	/ Org	ganization			
Street Address 2 Boylston Street 5th Floor						
City Boston	State	MA	-	ZIP Code 02111		
Office Telephone (Include Area Code) (617) 988-3165	E-Mail Add Michael.	ress Che	eung@hcf.state.ma.us			
Signature of Individual Muchael Character	Date 06/08/2010					
Signature of CMS Representative		Date				
Signature of CMS Project Officer (If applicable)		Date				
	,			· · · · · · · · · · · · · · · · · · ·		
Name and Title of Individual (typed or printed)						
Task / Role of this individual in this project		Company / Organization				
Street Address						
City	State			ZIP Code		
Office Telephone (Include Area Code)		E-Mail Add	ress	6 (If applicable)		
Signature of Individual		Date				
Signature of CMS Representative		Date				
Signature of CMS Project Officer (If applicable)		Date				

Addendum to DUA for Massachusetts	"The Role of Pub Health Care Expo	lically F enditures	77		. If this is a	n addendum to	a previously
approved DUA, insert the CMS assigned may/will have access to CMS data that it to the terms of this Data Use Agreement	s being reques	oer her sted fo	re: r this agree	ement.	Their signat	The following ures attest to the	individual(s) eir agreement
Name and Title of Individual (typed or printe Stacey Eccleston	ed)		-			***************************************	
Task / Role of this individual in this project Manager of Health Care Cost Con	t tainment		Company Divisio r	/ Orgai of He	nization ealthcare F	inance and	Policy
Street Address 2 Boylston Street				-			
City Boston	S	tate	MA	Z	IP Code	02116	
Office Telephone (Include Area Code) (617) 988-3276			E-Mail Address (If applicable) stacey.eccleston@state.ma.us				
Stgnature of Individual		Date 06/09/2010					
Signature of CMS Representative			Date				
Signature of CMS Project Officer (If applica	ble)		Date			<u>, , , , , , , , , , , , , , , , , , , </u>	
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Name and Title of Individual (typed or print	ed)						
Task / Role of this individual in this project	t		Company / Organization				
Street Address							, (),
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Office Telephone (Include Area Code)			E-Mail Ad	dress (h	f applicable)		
Signature of Individual			Date		· · · · · · · · · · · · · · · · · · ·		
Signature of CMS Representative			Date				
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Addendum to DUA for Massachusetts Health Care Expapproved DUA, insert the CMS assigned DUA nu	If this is an addendum to a previously The following individual(s)					
may/will have access to CMS data that is being req to the terms of this Data Use Agreement:	uested fo	or this agreeme	ent. Their signatures attest to their agreement			
Name and Title of Individual (typed or printed)						
Thomas S. Faiella. Task / Role of this individual in this project		Company / C	Organization			
Database Administrator		DHC	FP			
Street Address 2 Boylston Street City						
	State		ZIP Code			
Office Telephone (Include Area Code)	<u> </u>	1a_	SS (If applicable)			
		E-Mail Addre	SS (If applicable)			
617.988-3187		Thomas. Faiella@State.Ma.US				
Signature of Individual		Date 06/09	ss (Happilcable) b. Faiella@State.Ma.US 3/2010			
Signature of CMS Representative		Date	7			
Signature of CMS Project Officer (If applicable)		Date				
Name and Title of Individual (typed or printed)						
Task / Role of this individual in this project		Company / C	Organization			
Street Address						
City	State		ZIP Code			
Office Telephone (Include Area Code)		E-Mail Addre	SS (If applicable)			
Signature of Individual		Date				
Signature of CMS Representative		Date				
Signature of CMS Project Officer (If applicable)		Date				

Addendum to DUA for Massachusetts Health Care Expenditures." MA DHCFP's "The Role of Publically Financed Insurance in Massachusetts Health Care Expenditures." If this is an addendum to a previous pre						
approved DUA, insert the CMS assigned DUA nu			. The following individual(s)			
may/will have access to CMS data that is being req						
to the terms of this Data Use Agreement:	ucsica 10	dins agreemen	t. Then signatures attest to their agreement			
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Name and Title of Individual (typed or printed)						
Task/Role of this individual in this project SOFTWARL AR UHI TECT/DEWS	lopar	Company / Or	ganization DHFD			
Street Address						
2 BOY/STON ST						
City BOSTON	State M,	•	ZIP Code			
Office Telephone (Include Area Code) $617 - 988 - 3452$		E-Mail Address	(If applicable) - GNG @ 57ATE . MA . US			
Signature of Individual		Date 6/8/10				
Signature of CMS/Representative		Date /				
Signature of CMS Project Officer (If applicable)		Date				
Name and Title of Individual (typed or printed)						
Task / Role of this individual in this project		Company / Organization				
Street Address		<u> </u>	· ·			
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Office Telephone (Include Area Code)	1	E-Mail Address	S (If applicable)			
Signature of Individual		Date				
Signature of CMS Representative		Date				
Signature of CMS Project Officer (If applicable)		Date				

MA DHCFP's "The Role of Publi Massachusetts Health Care Exper	nditurno "		If this is an addendum to a previously				
		ere: The following individual(s)					
may/will have access to CMS data that is being req							
to the terms of this Data Use Agreement:		U					
Name and Title of Individual (typed or printed) Michael Grenier, Pricing Policy Manager							
Task / Role of this individual in this project Manager of payment reform projects		Company / C Division of	rganization Health Care Finance and Policy				
Street Address 2 Boylston Street							
City Boston	State	MA	ZIP Code 02116				
Office Telephone (Include Area Code) (617) 988-3192	ode)		E-Mail Address (If applicable) michael.grenier@state.ma.us				
Signature of Individual		Date 06/23/2010					
Signature of CMS Representative		Date					
Signature of CMS Project Officer (If applicable)		Date					
		1					
Name and Title of Individual (typed or printed)			And the second s				
Task / Role of this individual in this project	,	Company / Organization					
Street Address							
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Office Telephone (Include Area Code)		E-Mail Addre	SS (If applicable)				
Signature of Individual		Date					
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Signature of CMS Project Officer (If applicable)		Date					

Addendum to DUA for Massachusetts, Health Care Exapproved DUA, insert the CMS assigned DUA nu may/will have access to CMS data that is being requ	xpenditures. mber her	re:	If this is an addendum to a previously The following individual(s) tt. Their signatures attest to their agreement
to the terms of this Data Use Agreement:			
Name and Title of Individual (typed or printed) GETACHEW HABTEH-YIMER			and the state of t
Task / Role of this individual in this project Analyst		Company / Or Division of	ganization Healthcare Finance and Policy
Street Address 2 Boylston Street			
City Boston	State	MA	ZIP Code 02116
Office Telephone (Include Area Code) (617) 988-3131		E-Mail Addres getachew.h	s (frapplicable) abteh-yimer@state.ma.us
Signature of Individual Lebton Yiver		Date 06/09/2010	
Signature of CMS Representative		Date	
Signature of CMS Project Officer (If applicable)		Date	
Name and Title of Individual (typed or printed)	* · ·		And Associated Association and
Task / Role of this individual in this project	***	Company / Or	ganization
Street Address		<u>.</u>	
City	State		ZIP Code
Office Telephone (Include Area Code)		E-Mail Addres	S (If applicable)
Signature of Individual		Date	AMARASAN AM
Signature of CMS Representative		Date	
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Addendum to DUA for Massachusetts Health Care Expapproved DUA, insert the CMS assigned DUA numay/will have access to CMS data that is being request to the terms of this Data Use Agreement:	enditures." mber he	re:	If this is an addendum to a previously The following individual(s)			
Name and Title of Individual (typed or printed) Elizabeth Harney / Project Leader						
Task / Role of this individual in this project IT Project Leader	Company / Common	Organization wealth of Massachusetts / DHCFP				
Street Address 2 Boylston Street / 5th Floor						
City Boston	State	MA	ZIP Code 02116			
Office Telephone (Include Area Code) (617) 988-3288		E-Mail Address (If applicable) betty.harney@state.ma.us				
Signature of Individual		Date 6-4-2010				
Signature of CMS Representative		Date				
Signature of CMS Project Officer (If applicable)		Date				
		•				
Name and Title of Individual (typed or printed)						
Task / Role of this individual in this project		Company / Organization				
Street Address						
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Office Telephone (Include Area Code)	1	E-Mail Addr	ess (If applicable)			
Signature of Individual		Date				
Signature of CMS Representative		Date				
Signature of CMS Project Officer (If applicable)		Date				

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may/will have access to CMS data that is being requ	uested fo	r this agreemer	nt. Their signatures attest to their agreement			
to the terms of this Data Use Agreement:		•				
VV 114 VV1111 VV 1111 I I I I I I I I I I I I						
Name and Title of Individual <i>(typed or printed)</i> Young Joo, Health Policy Analyst						
Task / Role of this individual in this project Analyst	Company / Or MA Division	rganization in of Health Care Finance and Policy				
Street Address 2 Boylston Street						
City Boston	State	MA	ZIP Code 02116			
Office Telephone (Include Area Code) (617) 988-3241	•	E-Mail Addres young.joo@	ss (If applicable) Dstate.ma.us			
Signature of Individual	Date 06/04/2010					
Signature of CMS Representative		Date				
Signature of SMS Project Officer (If applicable)		Date .				
Address of the state of the sta						
Name and Title of Individual (typed or printed)						
Task / Role of this individual in this project	,	Company / Órganization				
Street Address						
City	State	AARIN AAR	ZIP Code			
Office Telephone (Include Area Code)		E-Mail Addres	SS (If applicable)			
Signature of Individual		Date				
Signature of CMS Representative		Date				
Signature of CMS Project Officer (If applicable)		Date				
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Name and Title of Individual (typed or printed)							
Chric Kane		•					
Task / Role of this individual in this project		Company / Or	ganization	11	1		
Hoplications Manager	-	Divis	ion of	HEALTY	CARR	Tran	
Street Address 2 Boy 1 Stan St						7	
City ,—	State		ZIP Code				
Soston	Ι (MA	C	2116			
Office Telephone (Include Area Code)		E-Mail Addres	S (If applicable)	State			
617 988-3274	Chris.	KARE (a	State	, ma	· us		
Signature of Individual		Date /	^ -			· · · · · · · · · · · · · · · · · · ·	
Chataget Som		6-8-2010					
Signature of CMS Representative		Date					
Signature of CMS Project Officer (If applicable)		Date					
Name and Title of Individual (typed or printed)							
Task / Role of this individual in this project		Company / Or	ganization			······································	
Street Address	-	<u> </u>				·	
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Office Telephone (Include Area Code)	<u>. I</u>	E-Mail Addres	S (If applicable)				
Signature of Individual		Date		· · · · · · · · · · · · · · · · · · ·		·······	
Signature of CMS Representative		Date			• • • • • • • • • • • • • • • • • • • •		
Signature of CMS Project Officer (If applicable)	······································	Date					

Addendum to DUA for Massachusetts Health Care Expapproved DUA, insert the CMS assigned DUA numay/will have access to CMS data that is being requote to the terms of this Data Use Agreement:	penditures." Imber he	re:	If this is an addendum to a previously The following individual(s)		
Name and Title of Individual (typed or printed) Michael Lichtman Database Administrator					
Task / Role of this individual in this project DBA		Company / Organization Commonwealth Of Mass DHCFP			
Street Address 2 Boylston St.					
City Boston	State	MA	ZIP Code 02116		
Office Telephone (Include Area Code) (617) 988-3157		E-Mail Address (If applicable) michael.lichtman@state.ma.us			
Signature of Individual		Date 06/08/2010			
Signature of CMS Répresentative		Date			
Signature of CMS Project Officer (If applicable)		Date			
Name and Title of Individual (typed or printed)					
Task / Role of this individual in this project		Company / Organization			
Street Address		<u> </u>			
City	State		ZIP Code		
Office Telephone (Include Area Code)		E-Mail Address (If applicable)			
Signature of Individual	ure of Individual		Date		
Signature of CMS Representative		Date			
Signature of CMS Project Officer (If applicable)		Date			

nditures."		If this is an addendum to a previously		
	***	The following individual(s) nent. Their signatures attest to their agreement		
alyst		<u> </u>		
	Company / Organization MA Division of Health Care Finance & Policy			
State	MA	ZIP Code 02116		
	E-Mail Address (If applicable) Sonja.Lee-Austin@state.ma.us			
	Date 06/04/2010			
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· //	,			
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State	***************************************	ZIP Code		
Telephone (Include Area Code)		E-Mail Address (If applicable)		
ignature of Individual		Date		
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	mber he uested for alyst	mber here: uested for this agreen alyst Company / MA Divis State MA E-Mail Addr Sonja.Lee 06/04/20 Date Date Company / Company / State E-Mail Addr Date Date Date Date Date Date Date Date		

Addendum to DUA for	ically Finan	ced Insurance in	If this is an addendum to a previously	
approved DUA, insert the CMS assigned DUA nu				
may/will have access to CMS data that is being req	uested fo	or this agreemer	at. Their signatures attest to their agreement	
to the terms of this Data Use Agreement:	a contract	× 4.23 agreen		
Thin ZAR MRA MIN				
Name and Title of Individual (typed or printed) Director of Health Care Data Analytics				
Task / Role of this individual in this project		Company / Organization HCF		
Street Address 2 Boylston St.				
City Boston	State	MA	ZIP Code 02116	
Office Telephone (Include Area Code) (617) 988-3153		E-Mail Addres thinzar.min	s (If applicable) @ state.ma.us	
Signature of Individual WWW	7	Date 6610		
Signature of CMS Representative		Date		
Signature of CMS Project Officer (If applicable)		Date		
-				
Name and Title of Individual (typed or printed)			40000	
Task / Role of this individual in this project		Company / Organization		
Street Address				
City	State		ZIP Code	
Office Telephone (Include Area Code)		E-Mail Address (If applicable)		
Signature of Individual		Date		
Signature of CMS Representative		Date		
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Addendum to DUA for	MA DHCFP's "The Role of Pul Massachusetts Health Care Exp	If this is an addendum to a previously			
approved DUA, insert th	e CMS assigned DUA n	. The following individual(s)			
may/will have access to (CMS data that is being re	quested fo	or this agreem	ent. Their signatures attest to their agreement	
to the terms of this Data			_	•	
10 1110 1013					
Name and Title of Individ	Jal (typed or printed)	LITA PL	JLAVARTI	`	
Task / Role of this individual in this project Analyst/Principal Tester		Company / Organization DHCFP/Health Data Analytics			
Street Address 2 Boylston Street, 4th	Floor				
City Boston		State	MA	ZIP Code 02116	
Office Telephone (Include Al (617) 988-3110	Office Telephone (Include Area Code) (617) 988-3110		E-Mail Addre	ess (# applicable) Lalita.Pulavarti@state.ma.us	
Signature of Individual Lautal .		Date 06/04/2010			
Signature of CMS Repres	entative		Date		
Signature of CMS Project	Officer (If applicable)		Date		
19444	The second of th				
Name and Title of Individ	ual (typed or printed)				
Task / Role of this individual in this project		,	Company / Organization		
Street Address					
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Signature of Individual		Date			
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Addendum to DUA for MA DHCFP's "The Role of Publ Massachusetts Health Care Expe	. If this is an addendum to a previously			
approved DUA, insert the CMS assigned DUA nu				
may/will have access to CMS data that is being req	uested fo	or this agreeme	ent. Their signatures attest to their agreement	
to the terms of this Data Use Agreement:	•	•		
Name and Title of Individual (typed or printed) Marjorie Radin				
Task / Role of this individual in this project Claim-level analysis	Company / Organization Division of Health Care Finance and Policy			
Street Address 2 Boylston Street				
City Boston	State	MA	ZIP Code 02116	
Office Telephone (Include Area Code) (617) 988-3216		E-Mail Addre marjorie.ra	ss (If applicable) adin@state.ma.us	
Signature of Individual	·	Date 06/10/2010		
Signature of CMS Representative		Date		
Signature of CMS Project Officer (If applicable)		Date		
Name and Title of Individual (typed or printed)				
Task / Role of this individual in this project		Company / Organization		
Street Address				
City	State		ZIP Code	
Office Telephone (Include Area Code)		E-Mail Address (If applicable)		
ignature of Individual		Date		
Signature of CMS Representative		Date		
Signature of CMS Project Officer (If applicable)		Date		

MA DHCFP's "The Role of Publi Addendum to DUA for Massachusetts Health Care Exper	. If this is an addendum to a previously			
approved DUA, insert the CMS assigned DUA nu		re:	The following individual(s)	
may/will have access to CMS data that is being requ	uested fo	or this agreemen	t. Their signatures attest to their agreement	
to the terms of this Data Use Agreement:			· · · · · · · · · · · · · · · · · · ·	
Name and Title of Individual (typed or printed)			1	
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Amy Smalarz, PhD	Jirec.	Company / Or		
Task / Role of this individual in this project	_ 0 _		Garaga C	
Project Specific managem	git.	Division	at Houth (are tinance and ve	
Street Address				
2 Bouldon St				
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Boston	Mo		62116	
Office Telephone (Include Area Code)	· · · / · · · ·	E-Mail Address	3 (If applicable)	
617-988-3213		O MANUS O	natarz Q State ma us	
Signature of Individual		Date	MACHINE E. CYSON IF IG. 505	
		6/7/10)	
Signature of CMS Representative		Date		
Signature of Civis Frenchesernative		Daic		
Of the state of th		Data		
Signature of CMS Project Officer (If applicable)		Date		
		<u> </u>		
Name and Title of Individual (typed or printed)	************			
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Task / Role of this individual in this project		Company / Or	ganization	
table, troso of the individual in the project			3	
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01	Louis		710.0-4-	
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Office Telephone (Include Area Code)		E-Mail Address	S (If applicable)	
Signature of Individual		Date		
Signature of CMS Representative		Date		
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Signature of CMS Project Officer (If applicable)		Date		
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Addendum to DUA for Massachusetts Health Care Expe	ed Insurance in If this is an addendum to a previously			
approved DUA, insert the CMS assigned DUA nu	ere: The following individual(s)			
may/will have access to CMS data that is being req	uested fo	or this agreer	nent. Their signatures attest to their agreement	
to the terms of this Data Use Agreement:	-			
		•		
Name and Title of Individual (typed or printed) Paul Smith / Health Policy Analyst				
Task / Role of this individual in this project Analyst, Principal Tester	Company / Organization MA Division of Health Care Finance and Policy			
Street Address 2 Boylston St				
City Boston	State	MA	ZIP Code 02116	
Office Telephone (Include Area Code) (617) 988-3242		E-Mail Add paul.smit	ress (If applicable) h@state.ma.us	
Signature of Individual,		Date 6/4/10		
Signature of CMS Representative		Date		
Signature of CMS Project Officer (If applicable)		Date		
***************************************		<u> </u>		
Name and Title of Individual (typed or printed)				
Task / Role of this individual in this project		Company / Organization		
Street Address		<u> </u>		
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fice Telephone (Include Area Code)		E-Mail Address (If applicable)		
Signature of Individual		Date		
Signature of CMS Representative		Date		
Signature of CMS Project Officer (If applicable)		Date		

MA DHCFP's "The Role of Pub	lically Finar				
Addendum to DUA for Massachusetts Health Care Expe		If this is an addendum to a previously			
approved DUA, insert the CMS assigned DUA nu					
may/will have access to CMS data that is being req	uested fo	r this agreemen	t. Their signatures attest to their agreement		
to the terms of this Data Use Agreement:					
Name and Title of Individual (typed or printed)	a Vi	uong, M	ealth Policy Analyst ganization, Health Care Finance and Police		
Task / Role of this individual in this project Analyst principal tester	ک ٔ	Company/Or Division of	ganization, () Health Care Finance and Police		
Analyst, principal dester Street Address & Bay/sten Street		1	0		
City Boston	State	MA	ZIP Code 02116		
Office Telephone (Include Area Code) (SSEE 12.12.13.	1917	E-Mail Address	(lif applicable) Yuong (a) State, ma. u.S		
617-988-31-7 Owleded and	· Listan C		uong (a) State, ma. us		
Signature of Individual Realwary		Date 0 06/07/2010			
Signature of CMS Representative		Date			
Signature of CMS Project Officer (If applicable)		Date			
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Name and Title of Individual (typed or printed)					
The second of th	The second	•			
Task / Role of this individual in this project	The section of the se	Company / Or	ganization		
Street Address		<u> </u>			
City	State		ZIP Code		
Office Telephone (Include Area Code)		E-Mail Address (If applicable)			
Signature of Individual		Date			
0		Data			
Signature of CMS Representative		Date			
Signature of CMS Project Officer (If applicable)		Date			

MA DHCI'P's "The Role of P Addendum to DUA for Massachusetts Health Care E	nanced Insurance i ."	nsurance in . If this is an addendum to a previously		
approved DUA, insert the CMS assigned DUA nu		* *		
may/will have access to CMS data that is being req to the terms of this Data Use Agreement:				
Name and Title of Individual (typed or printed) Julia Wenger	North Control of the	·		
Task / Role of this individual in this project Analyst	Company / Organization Division of Healthcare Finance and Policy			
Street Address 2 Boylston Street				
City Boston	State	MA	ZIP Code 02116	
Office Telephone (Include Area Code) (617) 988-3364	Office Telephone (Include Area Code) 617) 988-3364		ss (f applicable) er@state.ma.us	
Signature of Individual		Date 06/09/2010		
Signature of CMS Representative		Date		
Signature of CMS Project Officer (If applicable)		Date		
	-	,		
Name and Title of Individual (typed or printed)		e e de e di		
Task / Role of this individual in this project		Company / Organization		
Street Address				
City	State		ZIP Code	
Office Telephone (Include Area Code)		E-Mail Address (If applicable)		
Signature of Individual		Date		
Signature of CMS Representative		Date		
Signature of CMS Project Officer (If applicable)		Date		

Addendum to DUA for <u>Massachusetts Health Care Exp</u> approved DUA, insert the CMS assigned DUA nu	MA DHCFP's "The Role of Publically Financed Insurance in dum to DUA for Massachusetts Health Care Expenditures." yed DUA, insert the CMS assigned DUA number here:				
may/will have access to CMS data that is being req to the terms of this Data Use Agreement:	uested fo	r this agreemen	tt. Their signatures attest to their agreement		
Name and Title of Individual (typed or printed) DERICA 156 U) Task / Role of this individual in this project	سماك				
Task / Role of this individual in this project		Company / Organization			
Street Address 2 Boy USTAN STATET,	avi	,	N HEALTH (ARE FINITULE)		
BUSTON	State	n A	ZIP Code		
Office Telephone (Include Area Code)		E-Mail Address (If applicable) DEBORA. WONG BSTATE. MA. 15			
Signature of Individual Alm DW		Date 61	8/2010		
Signature of CMS Representative		Date	····		
Signature of CMS Project Officer (If applicable)		Date			
Name and Title of Individual (typed or printed)					
Task / Role of this individual in this project		Company / Or	ganization		
		<u></u>			
Street Address					
City	State		ZIP Code		
Office Telephone (Include Area Code)		E-Mail Address (If applicable)			
Signature of Individual		Date			
Signature of CMS Representative		Date			
Signature of CMS Project Officer (If applicable)		Date			